Complete Summary

GUIDELINE TITLE

Content of a complete routine second trimester obstetrical ultrasound examination and report.

BIBLIOGRAPHIC SOURCE(S)

Cargill Y, Morin L. Content of a complete routine second trimester obstetrical ultrasound examination and report. J Obstet Gynaecol Can 2009 Mar;31(3):272-75. [11 references]

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Second trimester pregnancy (18-22 weeks gestation)
- Fetal anomalies
- Maternal pelvic pathology

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Prevention
Screening

CLINICAL SPECIALTY

Obstetrics and Gynecology

INTENDED USERS

Advanced Practice Nurses
Allied Health Personnel
Nurses
Physician Assistants
Physicians

GUIDELINE OBJECTIVE(S)

To review the benefits of and requirements for a complete second trimester ultrasound and the documentation needed

TARGET POPULATION

Pregnant women between 18 and 22 weeks' gestation

INTERVENTIONS AND PRACTICES CONSIDERED

1. Complete routine second trimester ultrasound examination
2. Documentation required for the ultrasound report

MAJOR OUTCOMES CONSIDERED

- Number of fetuses
- Gestational age of fetus
- Location of placenta
- Fetal and maternal anatomy
- Infant death rate from congenital anomalies

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The American Institute of Ultrasound in Medicine's "Practice Guideline for the Performance of Obstetric Ultrasound Examinations," the American College of Obstetricians and Gynecologists' practice bulletin, "Ultrasound in Pregnancy," and the Royal College of Obstetricians and Gynaecologists' Working Party Report, "Ultrasound Screening," were reviewed. PubMed and the Cochrane Database were searched using the words "routine second trimester obstetrical ultrasound."

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Quality of Evidence Assessment*

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one center or research group.

II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

*Adapted from the Evaluation of Evidence criteria described in the report of the Canadian Task Force on Preventive Health Care.

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

The evidence was evaluated using the guidelines developed by the Canadian Task Force on Preventive Health Care.

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Classification of Recommendations*

A. There is good evidence to recommend the clinical preventive action.

B. There is fair evidence to recommend the clinical preventive action.

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.

D. There is fair evidence to recommend against the clinical preventive action.

E. There is good evidence to recommend against the clinical preventive action.

I. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

*Adapted from the Classification of Recommendations criteria described in the report of the Canadian Task Force on Preventive Health Care.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

This clinical practice guideline has been reviewed by the Diagnostic Imaging Committee and approved by the Executive and Council of the Society of Obstetricians and Gynaecologists of Canada.

The Society of Obstetricians and Gynaecologists of Canada acknowledges advisory input from the Canadian Association of Radiologists pertaining to imaging guidelines in the creation of this document.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The quality of evidence (I-III) and classification of recommendations (A-E, I) are defined at the end of the "Major Recommendations" field.

1. Pregnant women should be offered a routine second trimester ultrasound between 18 and 22 weeks' gestation. **(II-2B)**

2. Second trimester ultrasound should screen for the number of fetuses, the gestational age, and the location of the placenta. **(II-1A)**
3. Second trimester ultrasound should screen for fetal anomalies. **(II-2B)**

The table below shows the recommended content of the ultrasound report, but other information may be provided in such consultations.

Table: Content of a Complete Obstetrical Ultrasound Report

Category	Required Information
Patient demographic information	• Patient name, second patient identifier (birth date, hospital identifier, health insurance number) • Indication for consultation • Requesting physician/caregiver (preferably with contact information) • Starting date of last normal menstrual period (LNMP) • Examination date • Date of written report • Name of interpreting physician
Number of fetuses and indications of life	• Presence of cardiac activity for each fetus • If multiple gestation: chorionicity and amnionicity should be reported
Biometry	Should be reported all in millimetres or in centimetres along with equivalent estimated gestational age for: • Biparietal diameter • Head circumference • Abdominal circumference • Femur length Should be reported in millimetres if abnormal: • Nuchal fold • Cisterna magna • Cerebellar diameter • Lateral ventricle width
Fetal anatomy	Should be reported as: normal OR abnormal (with details) OR not seen, with explanation Should be reported for: • Cranium • Cerebral ventricles, cavum septi pellucidi, the midline falx, the choroid plexus • Posterior fossa: cisterna magna, cerebellum

Category	Required Information
	• Face: orbits, lips • Spine • Chest • Cardiac four-chamber view • Cardiac outflow tracts • Heart axis • Cardiac situs • Stomach • Bowel • Kidneys • Bladder • Abdominal cord insertion • Number of cord vessels • Upper extremities and presence of hands • Lower extremities and presence of feet
Amniotic fluid amount	Should be reported as: normal OR increased OR decreased OR absent
Placenta	Position should be reported as well as relationship to the cervical os
Maternal anatomy uterus, ovaries, cervix, bladder	Should be reported as: • Normal OR abnormal with details OR not seen

Definitions:

Levels of Evidence*

I: Evidence obtained from at least one properly designed randomized controlled trial.

II-1: Evidence obtained from well-designed controlled trials without randomization.

II-2: Evidence obtained from well-designed cohort (prospective or retrospective) or case-control studies, preferably from more than one center or research group.

II-3: Evidence obtained from comparisons between times or places with or without the intervention. Dramatic results in uncontrolled experiments (such as the results of treatment with penicillin in the 1940s) could also be included in this category.

III: Opinions of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees.

Grades of Recommendation**

A. There is good evidence to recommend the clinical preventive action.

B. There is fair evidence to recommend the clinical preventive action.

C. The existing evidence is conflicting and does not allow to make a recommendation for or against use of the clinical preventive action; however, other factors may influence decision-making.

D. There is fair evidence to recommend against the clinical preventive action.

E. There is good evidence to recommend against the clinical preventive action.

I. There is insufficient evidence (in quantity or quality) to make a recommendation; however, other factors may influence decision-making.

*The quality of evidence reported in these guidelines has been adapted from The Evaluation of Evidence criteria described in the report of the Canadian Task Force on Preventive Health Care.

**Recommendations included in these guidelines have been adapted from the Classification of Recommendations criteria described in the report of the Canadian Task Force on Preventive Health Care.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for each recommendation (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

A routine complete second trimester ultrasound between 18 and 22 weeks and a complete ultrasound report will:

- Provide the best opportunity to diagnose fetal anomalies and to assist in the management of prenatal care
- Reduce the number of ultrasound examinations done during the second trimester for completion of fetal anatomy survey

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed. Local institutions can dictate amendments to these opinions. They should be well documented if modified at the local level. None of these contents may be reproduced in any form without prior written permission of the Society of Obstetricians and Gynaecologists of Canada (SOGC).
- It is acknowledged that even in the best of hands and circumstances, the 18-22 week scan has limitations and cannot detect all fetal and maternal abnormalities.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

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ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2009 Mar

GUIDELINE DEVELOPER(S)

Society of Obstetricians and Gynaecologists of Canada - Medical Specialty Society

SOURCE(S) OF FUNDING

Society of Obstetricians and Gynaecologists of Canada

GUIDELINE COMMITTEE

Diagnostic Imaging Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Disclosure statements have been received from all members of the committee.

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Society of Obstetricians and Gynaecologists of Canada Web site.

Print copies: Available from the Society of Obstetricians and Gynaecologists of Canada, La société des obstétriciens et gynécologues du Canada (SOGC) 780 promenade Echo Drive Ottawa, ON K1S 5R7 (Canada); Phone: 1-800-561-2416

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI Institute on August 12, 2009. The information was verified by the guideline developer on August 19, 2009.

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Date Modified: 9/14/2009


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